

CLAIM FOR MEDICAL EXPENSES FOR CONSULTANTS/PSA/NPPP UNDER MCS PLAN

CLAIMANT TO COMPLETE *(typewritten or in block letters)*

Claimant's Surname, First Name	Index No.	Age	Division	Duty Station
Type of Appointment <input type="checkbox"/> Consultant <input type="checkbox"/> Personal Services Agreement Subscriber <input type="checkbox"/> National Professional Project Personnel <input type="checkbox"/> Short-Term Staff, including conference staff (less than 12 months) <input type="checkbox"/> Volunteer <input type="checkbox"/> WAE Consultant – Copy of Attendance report to be attached.				Email: _____ Address: _____ Phone: _____
Claim for medical expenses Date illness commenced: _____. Date of treatment: _____ Is the claimant covered by other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" state amount reimbursed \$ _____				
Amount claimed and currency: Please attach original receipted bills including treatment and diagnosis in a sealed envelope to be sent to Personnel Officer for certification of the claim (which will be opened only by the insurer).				
Please make payment to me as follows: Direct bank transfer to (average processing 1 week): name and address of bank : _____ Currency : _____ Account number : _____ ABI : _____ CAB : _____ IBAN: _____ Name of Account Holder : _____ Routing Number and/or ABA-SWIFT Code _____ or Cheque in my name to be mailed to me at the address shown at the top (average processing 3 weeks): _____				
NOTE: I understand that submission of a false or fraudulent claim is grounds for disciplinary action and voiding of the claim. Date: _____ Claimant's Signature: _____				
FOR COMPLETION BY THE DIVISIONAL PERSONNEL OFFICER or FAOR for locally recruited national consultants/NPPPs I certify that: <input type="checkbox"/> Claimant was employed when treatment received <input type="checkbox"/> Claimant was covered by MCS (please attach a copy of the contract) <input type="checkbox"/> Dates of appointment are from: _____ to: _____ Name of Personnel Officer/FAOR: _____ Date: _____ Signature: _____ Email _____@_____				

IMPORTANT: THIS FORM IS NOT TO BE USED FOR EXPENSES RELATED TO SERVICE-INCURRED ACCIDENT OR ILLNESS WHICH ARE REIMBURSABLE UNDER MANUAL SECTION 342 AND SHOULD BE SUBMITTED TO THE SECRETARY, ADVISORY COMMITTEE ON COMPENSATION CLAIMS, AFHS, TOGETHER WITH COMPLETED FORM “ADM 62” – REPORT OF ACCIDENT, ILLNESS OR DEATH.

INSTRUCTIONS FOR COMPLETION OF FORM

1. Claims for reimbursement of medical expenses require that the following documents must be attached in a sealed envelope for the insurer/broker's processing. It is emphasized that in order to ensure confidentiality of this medical information, the envelope will be opened *only* by the insurers.
 - a) Medical certificate on doctor's own stationery showing diagnosis, treatment prescribed and dates of visits.
 - b) Itemized original receipted bills for all expenses incurred;
 - c) Summary translation in one of the Organization's working languages of certificates, bills and prescriptions if written in a language other than English, French, Spanish or Italian.
2. The claimant must complete the top section of the claim form and attached the original paid bills in a sealed envelope. These two items must then be given to the Personnel Officer who will complete the bottom section of the claim form. Both items will then be forwarded to De Besi-Di Giacomo, FAO's broker, in Rome, Room D-006 for processing.
3. The claimant's attention is drawn to the exclusions listed in Manual Section 343, Part. VI, and in particular to the following exclusions:
 - (i) expenses for dental and optical treatment unless such treatment is rendered necessary as a result of an accident and;
 - (ii) expenses relating to pregnancy and complications arising there from.
4. Two options are shown for receiving reimbursement: electronic transfer or paper cheque. As shown on the payment instruction section, electronic reimbursement of claims is substantially faster than issuance of a cheque. The processing times are averages subject to receipt of all necessary documentation by DeBesi-DiGiacomo. The full postal address to which the broker should send the cheque should be indicated if the claim is to be paid by cheque.
5. The Broker will return a copy of the claim to the claimant indicating the amount reimbursed. The conversion of medical expenses sustained by the claimant in currencies other than US dollars will be made at the United Nations operational rate of exchange in force on the date of the treatment. Any question regarding the settlement of claims should be addressed to De Besi-Di Giacomo SpA, Room D-006, c/o FAO, Viale delle Terme di Caracalla, 00100 Rome, Italy or e-mail address mcs-mcns@debesidigiacomio.it or Medical-Insurance@fao.org. In case of dispute, copies of the correspondence may be sent to Social Security, AFHS, FAO Headquarters.
6. Claims for medical expenses will be settled by De Besi-Di Giacomo directly with the claimant.